FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022905

Facility Name: JOLIET TERRACE

Address: 2230 MCDONOUGH (Number) JOLIET (City) 60436 (Zip Code)

County: WILL

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883283

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	41,848	1,068		42,916	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,848	1,068		42,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.98%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,602	14,383	5,940	180,925		180,925		180,925			1
2	Food Purchase		153,824		153,824		153,824	(42)	153,782			2
3	Housekeeping	142,591	19,148		161,739		161,739		161,739			3
4	Laundry	67,196	12,602		79,798		79,798	932	80,730			4
5	Heat and Other Utilities			85,408	85,408		85,408	260	85,668			5
6	Maintenance	60,572	40,350	12,936	113,858		113,858	7,370	121,228			6
7	Other (specify):*			7,207	7,207		7,207	56	7,263			7
8	**TOTAL General Services**	430,961	240,307	111,491	782,759		782,759	8,576	791,335			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	986,035	33,477	13,160	1,032,672		1,032,672		1,032,672			10
10a	Therapy	142,072		2,223	144,295		144,295		144,295			10a
11	Activities	147,684	7,865	2,112	157,661		157,661		157,661			11
12	Social Services			3,146	3,146		3,146		3,146			12
13	CNA Training			585	585		585		585			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,275,791	41,342	24,226	1,341,359		1,341,359		1,341,359			16
	C. General Administration											
17	Administrative	75,000		231,000	306,000		306,000	(211,213)	94,787			17
18	Directors Fees											18
19	Professional Services			69,982	69,982		69,982	(4,928)	65,054			19
20	Dues, Fees, Subscriptions & Promotions			9,413	9,413		9,413	(1,800)	7,613			20
21	Clerical & General Office Expenses	85,762	19,611	139,771	245,144		245,144	(105,787)	139,357			21
22	Employee Benefits & Payroll Taxes			258,856	258,856		258,856		258,856			22
23	Inservice Training & Education			3,517	3,517		3,517	18	3,535			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			16,050	16,050		16,050	367	16,417			25
26	Insurance-Prop.Liab.Malpractice			45,387	45,387		45,387	1,760	47,147			26
27	Other (specify):*			12,381	12,381		12,381	(7,601)	4,780			27
28	**TOTAL General Administration**	160,762	19,611	786,357	966,730		966,730	(329,184)	637,546			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,867,514	301,260	922,074	3,090,848		3,090,848	(320,608)	2,770,240			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		42,260	
	ELECTRICITY		33,323	
	WATER		9,825	
	CABLE TV - LOBBY		0	
			0	85,408
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,770	
	PAINTING & DECORATING		733	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,222	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,588	
	FIRE SERVICE		1,623	
			0	
			0	
			0	12,936
7	**OTHER**			
	SCAVENGER		7,207	
	SECURITY SERVICE			7,207
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	3,000	3,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		4,530	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,030	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,600	
			0	13,160
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,454	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	769	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,223
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,112	
			0	2,112
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,146	
			0	3,146
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	585	585

Facility Name & ID Number JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	231,000	231,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,952	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	57,030	
			0	69,982
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	375	
	EMPLOYEE WANT ADS	XIX F	329	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,451	
	LICENSES & PERMITS	XIX F	2,049	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	700	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,381	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	128	9,413
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		112	
	EQUIPMENT REPAIR & MAINTENANCE		6,316	
	OUTSIDE CLERICAL SERVICES		66,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	321	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,189	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		51,833	139,771

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	141,451	
	UNEMPLOYMENT COMPENSATION	XIX D	26,047	
	WORKERS COMPENSATION INSURANCI	XIX D	62,508	
	HOSPITALIZATION INSURANCE	XIX D	20,858	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,992	
	CHICAGO HEAD TAX	XIX D		258,856
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,517	3,517
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		16,050	16,050
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		45,387	45,387
27	**OTHER**			
	BAD DEBTS	VI 24	12,381	
				12,381

GRAND TOTAL COLUMN 3 OTHER 922,074

JOLIET TERRACE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	153,824	PATIENT MEALS	128748
LESS SALES TAX	(42)	ADD EMPLOYEE MEALS	0
NET FOOD	153,782	TOTAL MEALS/YEAR	128748
TOTAL PATIENT CENSUS	42,916	NET FOOD	153782
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	128748
TOTAL PATIENT MEALS	128748	COST PER MEAL	1.19
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number JOLIET TERRACE #0022905 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,513	42,513		42,513	7,184	49,697			30
31	Amortization of Pre-Op. & Org.			2,428	2,428		2,428		2,428			31
32	Interest			58,532	58,532		58,532	46	58,578			32
33	Real Estate Taxes			36,927	36,927		36,927	1,280	38,207			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,786	25,786		25,786	3,489	29,275			35
36	Other (specify):* **OFFICE RENT**			9,360	9,360		9,360	(9,360)				36
37	**TOTAL Ownership**			175,546	175,546		175,546	2,639	178,185			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,700	65,700		65,700		65,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,867,514	301,260	1,163,320	3,332,094		3,332,094	(317,969)	3,014,125			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,189	30		9
10	Interest and Other Investment Income	(1,293)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	2		13
14	Non-Care Related Interest	(26)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(700)	20		17
18	Fines and Penalties	(321)	21		18
19	Entertainment		20		19
20	Contributions	(1,381)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(12,418)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,381)	27		24
25	Fund Raising, Advertising and Promotional	(375)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5-A	(55,213)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (77,961)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(240,008)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (240,008)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (317,969)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

JOLIET TERRACE

ID# 0022905

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 5,620	6	1
2	STAFF DEVELOPMENT	(51,833)	21	2
3	MARKETING SALARIES	(9,000)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,213)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(42)	0	0	0	0	0	0	0	0	0	0	(42)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	932	0	0	0	0	0	0	0	0	932	4
5	Heat and Other Utilities	0	0	0	260	0	0	0	0	0	0	0	260	5
6	Maintenance	5,620	0	1,234	516	0	0	0	0	0	0	0	7,370	6
7	Other (specify):*	0	0	27	29	0	0	0	0	0	0	0	56	7
8	**TOTAL General Services**	5,578	0	2,193	805	0	0	0	0	0	0	0	8,576	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(216,196)	4,983	0	0	0	0	0	0	0	0	(211,213)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,418)	320	7,127	43	0	0	0	0	0	0	0	(4,928)	19
20	Fees, Subscriptions & Promotions	(2,456)	0	656	0	0	0	0	0	0	0	0	(1,800)	20
21	Clerical & General Office Expenses	(61,154)	4,656	(49,496)	207	0	0	0	0	0	0	0	(105,787)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	18	0	0	0	0	0	0	0	0	18	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	53	314	0	0	0	0	0	0	0	0	367	25
26	Insurance-Prop.Liab.Malpractice	0	132	1,471	157	0	0	0	0	0	0	0	1,760	26
27	Other (specify):*	(12,381)	1,428	3,352	0	0	0	0	0	0	0	0	(7,601)	27
28	**TOTAL General Administration**	(88,409)	(209,607)	(31,575)	407	0	0	0	0	0	0	0	(329,184)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(82,831)	(209,607)	(29,382)	1,212	0	0	0	0	0	0	0	(320,608)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,189	0	172	823	0	0	0	0	0	0	0	7,184	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,319)	0	0	1,365	0	0	0	0	0	0	0	46	32
33	Real Estate Taxes	0	0	0	1,280	0	0	0	0	0	0	0	1,280	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	267	3,039	183	0	0	0	0	0	0	0	3,489	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	**TOTAL Ownership**	4,870	267	3,211	(5,709)	0	0	0	0	0	0	0	2,639	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(77,961)	(209,340)	(26,171)	(4,497)	0	0	0	0	0	0	0	(317,969)	45

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALITY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 225,000	EMI ENTERPRISES		$	$ (225,000)	1
2	V								2
3	V	17	OFFICERS SALARY				8,804	8,804	3
4	V	19	ACCOUNTING FEES				320	320	4
5	V	21	OFFICE EXPENSE				4,656	4,656	5
6	V	25	TRANSPORTATION				53	53	6
7	V	26	INSURANCE				132	132	7
8	V	27	EMPLOYEE BENEFITS				1,428	1,428	8
9	V	35	AUTO LEASE				267	267	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 225,000			$ 15,660	$ * (209,340)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 66,000	EKS MANAGEMENT	100.00%	$	$ (66,000)	15
16	V								16
17	V								17
18	V	4	HOUSEKEEPING SALARIES				932	932	18
19	V	6	PAINTERS SALARIES				1,234	1,234	19
20	V	7	SCAVENGER				27	27	20
21	V	17	CFO SALARY				4,983	4,983	21
22	V	19	PROFESSIONAL FEES				7,127	7,127	22
23	V	20	WANT ADDS/BACKGR CKS				656	656	23
24	V	21	OFFICE EXPENSE				16,504	16,504	24
25	V	23	SEMINARS				18	18	25
26	V	25	TRANSPORTATION				314	314	26
27	V	26	INSURANCE				1,471	1,471	27
28	V	27	EMPLOYEE BENEFITS				3,352	3,352	28
29	V	30	DEPRECIATION				172	172	29
30	V	35	EQUIPMENT RENT				3,039	3,039	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,000			$ 39,829	$ * (26,171)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,360	IME REALTY	100.00%	$	$ (9,360)	15
16	V								16
17	V								17
18	V								18
19	V	5	UTILITIES				260	260	19
20	V	6	REPAIR & MAINTENANCE				516	516	20
21	V	7	ALARM SERVICE				29	29	21
22	V	19	PROFESSIONAL FEES				43	43	22
23	V	21	OFFICE EXPENSE				207	207	23
24	V	26	INSURANCE				157	157	24
25	V	30	DEPRECIATION				823	823	25
26	V	32	INTEREST				1,365	1,365	26
27	V	33	RE TAX				1,280	1,280	27
28	V	35	STORAGE FEES				183	183	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,360			$ 4,863	$ * (4,497)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION		SEE ATTACHED			SALARY	$ 8,804	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	4,983	17-7	2
3	PHILIP ESFORMES							MGMT FEE	6,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,787		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	$ 185,000	$ 185,000	42,916	$ 8,804	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725		42,916	320	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	79,576	42,916	4,656	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114		42,916	53	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768		42,916	132	5
6	27	EMOLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997		42,916	1,428	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617		42,916	267	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 329,044	$ 264,576		$ 15,660	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	$ 19,581	$ 19,441	42,916	$ 932	1
2	6	PAINTERS SALARIES	PATIENT DAYS	901,761	15	25,925	25,925	42,916	1,234	2
3	7	SCAVENGER	PATIENT DAYS	901,761	15	573		42,916	27	3
4	17	CFO SALARY	PATIENT DAYS	901,761	15	104,714	104,714	42,916	4,983	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	119,638	42,916	7,127	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	901,761	15	13,787		42,916	656	6
7	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	42,916	16,504	7
8	23	SEMINARS	PATIENT DAYS	901,761	15	380		42,916	18	8
9	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593		42,916	314	9
10	26	INSURANCE	PATIENT DAYS	901,761	15	30,900		42,916	1,471	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423		42,916	3,352	11
12	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617		42,916	172	12
13	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848		42,916	3,039	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 836,892	$ 518,647		$ 39,829	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	346,361	16	$ 9,618	$	9,360	$ 260	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	346,361	16	19,083		9,360	516	2
3	7	ALARM SERVICE	RENTAL INCOME	346,361	16	1,056		9,360	29	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	346,361	16	1,575		9,360	43	4
5	21	OFFICE EXPENSE	RENTAL INCOME	346,361	16	7,666		9,360	207	5
6	26	INSURANCE	RENTAL INCOME	346,361	16	5,806		9,360	157	6
7	30	DEPRECIATION	RENTAL INCOME	346,361	16	30,446		9,360	823	7
8	32	INTEREST	RENTAL INCOME	346,361	16	50,514		9,360	1,365	8
9	33	RE TAX	RENTAL INCOME	346,361	16	47,364		9,360	1,280	9
10	35	STORAGE FEES	RENTAL INCOME	346,361	16	6,785		9,360	183	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,913	$		$ 4,863	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SOUTH TRUST BANK		X	MORTGAGE	$5,173.00	08/01/95	$ 1,795,000	$ 880,258	07/31/15		$ 42,631	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				188,000			15,875	6
7												7
8	RELATED PARTY	X									1,365	8
9	TOTAL Facility Related				$5,173.00		$ 1,795,000	$ 1,068,258			$ 59,871	9
	B. Non-Facility Related*											
10	IRS,IDR,ETC		X	LATE FEES							26	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 26	14
15	TOTALS (line 9+line14)						$ 1,795,000	$ 1,068,258			$ 59,897	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	34,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	35,627	2
3. Under or (over) accrual (line 2 minus line 1).	$	927	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	36,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	36,927	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	30,783	8
	2001	31,896	9
	2002	34,074	10
	2003	34,396	11
	2004	35,627	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JOLIET TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022905

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-18-300-016-0000	NURSING HOME	$ 35,626.50	$ 35,626.50
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,626.50	$ 35,626.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1976	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8	IME REALTY				27,612	791		791			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1979	3,802		10			3,802	9
10	BUILDING IMPROVEMENTS			1980	10,532		3			10,532	10
11	BUILDING IMPROVEMENTS			1980	7,500		10			7,500	11
12	BUILDING IMPROVEMENTS			1982	54,503	1,730	31.5	1,730		29,338	12
13	BUILDING IMPROVEMENTS			1983	2,495		10			2,495	13
14	BUILDING IMPROVEMENTS			1989	8,100		15			8,100	14
15	BUILDING IMPROVEMENTS			1990	19,140	608	20	957	349	13,877	15
16	BUILDING IMPROVEMENTS			1991	5,335	169	20	267	98	3,604	16
17	BUILDING IMPROVEMENTS			1992	17,257	548	31.5	548		6,896	17
18	BUILDING IMPROVEMENTS			1992	11,861	377	15	791	414	9,059	18
19	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,524	19
20	BUILDING IMPROVEMENTS			1993	14,238	366	39	366		4,176	20
21	BUILDING IMPROVEMENTS			1994	5,200	133	39	133		1,336	21
22	FLOORING INSTALL			1995	9,823	252	39	252		1,993	22
23	ROOFING			1995	12,675	325	39	325		2,477	23
24	TILES			1996	15,503	398	39	398		3,031	24
25	FLOOR TILES			1998	23,132	593	39	593		3,861	25
26	ROOFING			1999	17,100	438	39	438		2,538	26
27	BLINDS/WALLCOVERING/WINDOW TREATMENTS			2000	19,897	1,775	20	995	(780)	5,472	27
28	COVE & BASE			2000	2,679	98	27.5	98		565	28
29	SPRINKLER HEADS			2000	4,300	156	27.5	156		813	29
30	AIR CONDITIONS			2001	1,887	69	27.5	69		307	30
31	FLOOR TILES			2003	5,650	205	27.5	205		504	31
32	ROOFING			2003	26,800	975	27.5	975		2,397	32
33	HEATING			2003	33,836	1,230	27.5	1,230		3,024	33
34	WARDROBES WITH DRAWERS & SLIDING DOORS			2003	18,000	655	27.5	655		1,610	34
35	CARPETING			2004	5,028	183	27.5	183		267	35
36	FLOOR TILES			2004	8,800	320	27.5	320		466	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	KICKPLATES	2004	$ 3,158	$ 115	27.5	$ 115	$	$ 168	37
38	SMOKE DETECTORS	2004	7,500	272	27.5	272		397	38
39	FIRE ALARM SYSTEM	2005	62,300	1,038	27.5	1,038		1,038	39
40	PAVING	2005	19,000	950	15	950		950	40
41	WINDOWS, GENERATOR, DOORS, GLIDER UNITS	2005	33,466	558	27.5	558		558	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,755,174	$ 15,456		$ 15,537	$ 81	$ 1,367,675	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 331,410	$ 23,580	$ 32,889	$ 9,309	5-10	$ 206,903	71
72	Current Year Purchases	21,339	4,268	1,067	(3,201)	10	1,067	72
73	Fully Depreciated Assets	344,280					344,280	73
74			204	204				74
75	TOTALS	$ 697,029	$ 28,052	$ 34,160	$ 6,108		$ 552,250	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,552,203	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,508	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 49,697	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,189	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,919,925	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 0 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 17,419 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITIES	03 FORD E 350	$ 697.23	$ 8,367	17
18					18
19					19
20					20
21	TOTAL		$ 697.23	$ 8,367	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 120

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA [ ]

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		585		585
9	TOTALS	$	$ 585	$	$ 585
10	SUM OF line 9, col. 1 and 2 (e)	$ 585			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A				7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 111,779	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,557)	938,734		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,101		6
7	Other Prepaid Expenses	38,297		7
8	Accounts Receivable (owners or related parties)	525,769		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,698,680	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	494,562		15
16	Equipment, at Historical Cost	697,029		16
17	Accumulated Depreciation (book methods)	(2,038,761)		17
18	Deferred Charges	23,303		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 509,133	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,207,813	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 192,489	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	188,000		29
30	Accrued Salaries Payable	63,605		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,834		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,000		32
33	Accrued Interest Payable	1,315		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 504,243	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	880,258		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 880,258	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,384,501	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 823,312	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,207,813	$	48

*(See instructions.)

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 680,400	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 680,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	323,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(180,515)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 142,912	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 823,312	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,654,228	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,654,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,293	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,293	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,655,521	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,759	31
32	Health Care	1,341,359	32
33	General Administration	966,730	33
	B. Capital Expense		
34	Ownership	175,546	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,332,094	40
41	**Income before Income Taxes (line 30 minus line 40)****	323,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 323,427	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 60,000	$ 28.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,894	2,894	54,208	18.73	3
4	Licensed Practical Nurses	12,130	12,253	225,467	18.40	4
5	CNAs & Orderlies	47,121	53,679	501,476	9.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,241	12,733	142,072	11.16	8
9	Activity Director					9
10	Activity Assistants	14,121	14,838	147,684	9.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,779	18,137	160,602	8.85	15
16	Dishwashers					16
17	Maintenance Workers	5,121	5,528	60,572	10.96	17
18	Housekeepers	16,010	18,391	142,591	7.75	18
19	Laundry	6,992	8,251	67,196	8.14	19
20	Administrator	2,080	2,080	75,000	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,370	9,790	85,762	8.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	9,161	9,388	144,884	15.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,100	170,042	$ 1,867,514 *	$ 10.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,030	10-3	39
40	Physical Therapy Consultant	L	1,454	10a-3	40
41	Occupational Therapy Consultant	Y	769	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,112	11-3	44
45	Social Service Consultant	E	3,146	12-3	45
46	Other(specify) DENTAL	E	3,600		46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		$ 25,051		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JANET CANTELO	ADMIN	0	$ 75,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,000

B. Administrative - Other

Description		Amount
EMI MANAGEMENT	MANAGEMENT FEES	$ 225,000
PHILIP ESFORMES		6,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 231,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		69,982
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 69,982

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,508
Unemployment Compensation Insurance	26,047
FICA Taxes	141,451
Employee Health Insurance	20,858
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	7,992
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 258,856

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	329
Health Care Worker Background Check	128
(Indicate # of checks performed 9)	
MARKETING/ADV/PROMO	375
TRUST/FRANCHISE/CONTRIB/ETC	2,081
LICENSES & PERMITS	2,049
DUES & SUBSCRIPTIONS	4,451
MGMT CO ALLOCATION	656
TRUST/FRANCHISE/CONTRIB/ETC	(2,081)
Less: Public Relations Expense	(0)
Non-allowable advertising	(375)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,613

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2003	$ 14,769	3YRS	$	$ 2,462	$ 4,923	$ 4,923	$ 2,461	$	$	$	$
2	PAINT/DECORATING	2004	2,092	3YRS			349	697	697	349			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,861		$	$ 2,462	$ 5,272	$ 5,620	$ 3,158	$ 349	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL OF LONG TERM CARE $4451**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees